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MEDICAL AID TO THE AGED

by

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MEDICAL AID TO THE AGED

MEDICAL INSURANCE for men and women of advanced years has become a major political issue. Popular endorsement of government action to help old people pay doctor and hospital bills was made unmistakably clear after the House Ways and Means Committee on March 31 turned down a measure to extend such assistance through the social security system. The sudden swell of public support that then rapidly gained momentum reinforced the case of the Democratic supporters of the bill and sent Republicans scurrying to devise alternative proposals. The strong political appeal of medical aid to the aged became still more apparent in mid-April, when it was learned that Speaker Sam Rayburn (D Texas) had been persuaded to put his powerful influence to work in behalf of legislation of some kind in this field.

Rayburn's aid on the House side of the Capitol, matched, it is anticipated, by that of Majority Floor Leader Lyndon B. Johnson (D Texas) on the Senate side, means without much question that a bill will be laid before President Eisenhower before Congress adjourns. If the President withholds his signature, debate on the question in the coming campaign will be sharpened. But because the Democratic leaders of House and Senate are not expected to go all the way with backers of health insurance for the aged, any bill that may possibly win presidential approval will not end the debate. In all probability, neither parties nor presidential candidates will be able to limit platform pledges or campaign promises to sympathetic generalities; they will be under heavy pressure to take a specific stand on provision of adequate medical assistance to the growing proportion of the population in the upper age brackets.

GROWING PRESSURE FOR GOVERNMENT INSURANCE

Bills by Rep. Aime J. Forand (D R.I.) to increase social security taxes to finance hospitalization and other medical benefits for all persons drawing retirement benefits under

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the system have been before the House of Representatives since 1957. The Democratic leadership, however, gave little encouragement to supporters of Forand's proposals—mostly members of the party's liberal bloc. And the Republican administration consistently opposed extension of the social security system to include medical benefits. The House Ways and Means Committee held hearings on the Forand bill in 1958 and 1959, but a majority which included the Republican members and the Democratic chairman, Rep. Wilbur D. Mills (D Ark.), refused to report the measure. The vote against it on the last day of March 1960 was 17 to 8.

Since then, members of Congress are reported to have received more mail on old-age health insurance than on any other question. Many of the letters no doubt have been inspired by pressure groups, but a large number of them appear to have been of spontaneous origin; and the opinions expressed reportedly weigh heavily on the side of the Forand bill. On March 27, four days before the House committee acted, the three announced contenders for the Democratic presidential nomination—Sens. Hubert H. Humphrey (Minn.), John F. Kennedy (Mass.) and Stuart Symington (Mo.)—all came out for the bill in speeches at a United Automobile Workers rally in Detroit.

Popular support for health insurance legislation has been building up over a long period. Labor unions have sponsored lectures and discussions on the subject throughout the country, and union members have been prodded to write to their congressmen. A.F.L.-C.I.O. President George Meany recently asked all affiliated unions to stress the issue when congressmen were home for Easter: "Redouble all efforts to impress upon the members of Congress labor's unshaken support for legislation along the lines of the Forand bill."

Interest in helping retired persons to pay medical, surgical and hospital bills was increased last year as a result of hearings held in eight cities,¹ between June and December, by the Senate Labor Committee's Subcommittee on Problems of the Aged and Aging. The subcommittee took testimony from 200 public officials and other experts. Nearly as many old persons recounted the difficulties they had in paying medical bills. The subcommittee reported

¹ Boston, Charleston (W. Va.), Detroit, Grand Rapids, Miami, Pittsburgh, San Francisco, Washington.

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on Jan. 29 that "The No. 1 problem of America's senior citizens is how to meet the costs of health care at a time when income is lowest and potential or actual disability at its highest."

REPUBLICAN EFFORTS TO DEVISE ALTERNATIVE PLAN

With Democratic support for an attack on the problem through social insurance mounting, Republicans in increasing numbers concluded that it would be necessary to do more than merely stand fast against the Forand bill. Vice President Nixon, unopposed candidate for the Republican presidential nomination, had sponsored a health aid bill in the House a decade ago. According to report, he now urged the administration to support some definite plan aimed to satisfy popular demand for government health aid to the aged and enable his party to go into the campaign with a favorable record on the question.

Secretary of Health, Education and Welfare Arthur S. Flemming conferred with the President and Republican congressional leaders in March on alternative proposals. He subsequently informed reporters that the President had rejected all suggestions except one, and that his approval in that case was limited to endorsing further exploration of the plan. This was a plan for state and federal subsidies to help old persons with small incomes to take out health insurance policies issued by private companies.

Three Republican senators—John Sherman Cooper (Ky.), Jacob K. Javits (N.Y.) and Hugh Scott (Pa.)—announced on March 26 that they were drafting a bill calling for federal aid for voluntary insurance and hoped to win the support of the President. Senate Minority Floor Leader Everett McKinley Dirksen (R Ill.) asked the senators on April 5 to delay introduction of their bill until Flemming had appeared the next day before the Subcommittee on Problems of the Aged and Aging. But when the Secretary testified, he had no specific proposal to offer. He reported that he expected to complete consultations on the problem within two weeks and would then submit his recommendations to the White House. With further delay in prospect, Javits, now with seven Republican co-sponsors,² went ahead and introduced the new bill. As he did so on

² Sens. Aiken (Vt.), Case (N.J.), Cooper (Ky.), Fong (Hawaii), Keating (N.Y.), Prouty (Vt.), Scott (Pa.). Flemming on April 17 said two weeks more would be needed to complete his study.

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April 8, he observed that health care for the aged "ranks as a major domestic issue in the United States."

NUMBER OF OLD PEOPLE AND THE EXTENT OF NEED

The political importance of medical aid to the aged stems basically from the lengthening of the life span and the consequent increase in the proportion of old people in the population. This development not only augments the influence of elderly persons as a voting bloc but also affects the economic interests of younger persons. They are called on to help the needy aged, either directly by assisting relatives who can no longer support themselves or indirectly by paying taxes to finance public aid programs.

The 16 million persons in the United States aged 65 or more constitute 9 per cent of the total population; when social security legislation was first enacted in 1935, they made up only 6 per cent of the population. The number of old people in the country is increasing by about 1,000 every day; by 1975 there will be at least 20 million in the 65-and-over age group.

Funds to support this group, which is largely non-productive,³ traditionally came from savings accumulated during working years. To a large extent the living expenses of the elderly today are paid out of the proceeds of savings, private pensions, insurance and social security. But this income, while frequently sufficient to cover ordinary expenses, has proved generally inadequate to meet costs of serious illness.

Lack of adequate income for the latter purpose is due largely to developments in modern medicine which have made medical care increasingly expensive. Even sizable "rainy day" savings may be quickly consumed in a few weeks of hospitalization, leaving nothing to fall back on in subsequent emergencies. Another type of problem widely encountered among the aged is difficulty in budgeting for costly medicines which must be taken regularly to sustain good health.

The Subcommittee on the Problems of the Aged and Aging found that "Many older persons . . . could manage to live respectably on their modest incomes if they could eliminate the impact of heavy health costs." Some avoided

³ A survey in December 1968 showed that only one in five of the members of the older group held jobs. Approximately one-half of the group's total income was derived from pensions, public assistance, or other income-maintenance sources.

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going to the doctor or buying medicine when they fell ill, thus inviting more serious illness, while others skimped on food or other necessities to get needed medicines.

As a group, old persons have the lowest income. Three-fifths of persons 65 years of age or older had incomes of less than \$1,000 in 1958; only one-fifth had incomes of more than \$2,000. The poorest are widows, who make up a growing proportion of the aged. The average married woman now can expect to outlive her husband by 10 years; if the couple is solely dependent on social security benefits, the family income drops by one-half on the death of the primary beneficiary.

Proposals for Financing Aid to Aged

NONE of the proposals now under discussion to help old people pay their medical bills would give blanket coverage for all services, as is done in Great Britain under a government-financed national health service. The most generous provisions that have been suggested are comparable to what is offered by a basic private insurance policy. The chief advantage for those coming under the proposed programs would be aid in meeting the total costs of health insurance and continued protection without regard to age or previous medical history.

FORAND BILL: BENEFITS UNDER SOCIAL SECURITY

The Forand bill would amend the Social Security Act to provide insurance against the cost of hospital or nursing home care and the cost of surgical services for all persons eligible for old-age and survivors' insurance (O.A.S.I.) benefits. It would impose an additional social security payroll tax of one-fourth of one per cent each on employers and employees (three-eighths of one per cent on the self-employed) and raise the ceiling on annual earnings subject to the tax from the present \$4,800 to \$6,000. Twelve months after approval of the amended act, O.A.S.I. beneficiaries would become eligible to receive the following benefits:

Cost of hospital services (ambulance, staff and laboratory services, drugs, appliances, operating room) and room and board in a

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semi-private room for the first 60 days of hospitalization in any 12-month period.

Surgeon's fee for a necessary operation performed in a hospital or for emergency or minor surgery performed in the outpatient clinic or in the doctor's office.

Nursing home care (room and board and nursing, medical and personal services) for patients transferred from a hospital for continuation of care for the same or a consequent condition, up to a maximum of 120 days of combined hospital and nursing home care during a 12-month period.

Payments would be made out of the federal Old-Age and Survivors Insurance Trust Fund directly to suppliers of the services. Any hospital or nursing home (except tuberculosis or mental institutions) and surgeons or their designated associations could enter into agreements with the Secretary of Health, Education and Welfare for payment for services furnished to eligible patients. The amount of payment to hospital or nursing home would be determined "on the basis of the reasonable cost incurred . . . for all bed patients, or, when use of such a basis is impractical . . . or inequitable . . . on a reasonably equivalent basis which takes account of pertinent factors with respect to services furnished."

Private non-profit organizations which offer hospital, nursing home or surgical services or which operate voluntary insurance plans covering such services could make agreements with the government for reimbursement from O.A.S.I. funds for services to patients qualifying for benefits under the government program. The bill stipulates that institutions and individuals entering into agreements with the government must not require additional payments by patients other than payments for services not covered by the program. A hospital, for example, would be allowed to collect from a patient wanting a private room the difference between the charge for that accommodation and the charge for the semi-private room to which the insurance would entitle him.

Sen. Kennedy introduced last Jan. 26 a bill similar to the Forand bill with the exception that it would omit surgical coverage and extend the period of covered hospitalization from 60 days to 90 days. The Kennedy bill also would establish a National Advisory Health Council, composed of representatives of physicians, hospital managers and consumers, to advise the Secretary of Health,

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Education and Welfare in administering the program. A comparable bill was offered by Sen. Hubert H. Humphrey (D Minn.) in February 1959. The bills omitting surgical benefits were framed to meet objections to the Forand bill raised by the medical profession. All of the pending bills specifically sustain a patient's right of free choice of doctor or medical facility and prohibit supervision or control by any government agency of professional services rendered under the program.

Reports indicate that Speaker Rayburn's support of legislation in this field is limited to a bill providing only hospitalization benefits. By omitting surgical benefits, it is thought that the cost would be held down to an amount that could be financed by raising the ceiling of earnings subject to social security tax but without raising the rate of the tax itself. Additional annual revenue from raising the ceiling to \$6,000 has been estimated at \$900 million. Estimates of the cost of the Forand bill range from \$1.1 billion to \$2 billion a year.

ADMINISTRATION APPROACH; TERMS OF JAVITS BILL

President Eisenhower has steadily maintained that he will approve no measure which adds any form of health insurance to the social security system. However, Sen. Dirksen disclosed, April 5, that the administration would support a health insurance bill if participation was kept voluntary, if benefits were limited and costs held down, and if no increase in social security taxes was required. The administration insisted (1) that any program to ease the financial burden of illness on old persons must be based on existing non-governmental programs, (2) that it must encourage extension of private insurance to the aged, and (3) that it must be administered by the states. Any federal funds made available for the program would have to come from general tax receipts, not from the social security trust fund, and the federal contribution would have to be relatively small. Beneficiaries would be limited to old persons who could not afford private insurance, regardless of their status under social security. Dirksen suggested that the charges might be adjusted to an individual's income.

The Javits bill would require establishment or designation by state legislatures of an agency in each state to contract with private insurance companies to provide coverage for the eligible aged or to set up their own state-operated

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insurance systems. Every person aged 65 or more, and the wife of such a person whatever her age, would be permitted but not required to subscribe. Subscription rates would be \$13 a month (\$26 for a couple), to be paid in full by persons with annual income in excess of \$3,600. Those with less income would pay proportionately smaller amounts, down to 50c a month when income amounted to between \$500 and \$1,000, and to nothing at all when income was under \$500. Public funds would make up the difference for persons not paying full rates. The subsidy would come from state and federal grants. The federal share, determined under a formula based on state per capita income, would run from one-third to three-fourths of the total.

Javits said on April 7 that insurance companies had estimated that, for the \$156 annual basic rate, subscribers could be given 60 days of hospital or nursing home care, surgery in or out of a hospital, visits to a doctor's office for needed laboratory tests, diagnostic X-rays, specialist consultations, and the services of a visiting nurse at home. This is a bigger bundle than would be provided under the Forand bill and, in addition, it would cover the four or five million elderly persons who are not eligible for social security benefits.

Although the bill embodies most of the principles favored by the administration, the size of the federal contribution might be a bar to White House approval. Sponsors of the measure have estimated that if 70 per cent of those eligible participated in the program, the annual cost would be \$1,520,000,000. Insured persons would pay \$400 million; the states, \$640 million; and the federal government \$480 million. The President has been represented as opposing a federal expenditure of as much as \$100 million for this purpose.

PREVIOUS FEDERAL HEALTH INSURANCE PROPOSALS

The Javits and Forand bills, except for limitation to a particular age group, differ little in principle from a host of other measures for financing health care which have been put before Congress over the past two decades. The Social Security Act of 1935 was only three years old when a technical committee of government officials⁴ proposed that

⁴Members of the committee included officials of the U.S. Public Health Service, Social Security Board, and U.S. Children's Bureau.

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it be amended to embrace health insurance. Sen. Robert A. Wagner (D N.Y.), who introduced a bill to that effect in 1939, said: "Social insurance against the hazards of sickness is the next logical and, I believe, inevitable step for this country in its program of security for the people." No action was taken on the measure and, upon the advent of war, interest in the subject subsided.⁵

President Roosevelt nevertheless included the "right to adequate medical care" in his "Economic Bill of Rights" on Jan. 11, 1944. President Truman took up the problem immediately after the war. In a special message to Congress in October 1945 he proposed that "financial barriers in the way of attaining health . . . be removed . . . through expansion of our existing compulsory social insurance system to cover all persons who work for a living and their dependents."

An administration bill, with the title "National Health Act," was introduced on Nov. 19, 1945, in the Senate by Sens. Wagner and James E. Murray (D Mont.) and in the House by Rep. John D. Dingell (D Mich.). Three Republicans—Sens. Robert A. Taft (Ohio), H. Alexander Smith (N.J.), and Joseph H. Ball (Minn.)—countered with a substitute, offered May 3, 1946, which proposed greatly increased federal aid for medical care of the needy through state programs, the states to utilize private insurance for the purpose if they so desired.

These two bills, reflecting opposing views on social insurance for health care, set the stage for a political tug-of-war over the issue of "socialized medicine" which continued for the remainder of the Truman administration. Truman repeatedly raised the issue, new variants of the different types of bills were successively introduced, and hearings on health insurance were held annually from 1946 through 1950. Although Congress liberalized the social security program in other respects, it took no action on health insurance.

Finally in 1951 Truman appointed a Commission on the Health Needs of the Nation, headed by Dr. Paul B. Magnuson, to make an extended study. Among the numerous recommendations offered in its report, *Building America's*

⁵ The American Public Health Association proposed in 1943 that diagnostic and preventive medical services, financed by social insurance and general taxation, be made available to the entire population.

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Health (1952), the commission proposed that "funds collected through the O.A.S.I. mechanism be utilized to purchase personal health service benefits on a prepayment basis for beneficiaries of that insurance program."

Many of the bills introduced in that period were aimed at helping low-income and high-risk groups, such as the aged, to pay for participation in some form of health insurance. Bills like the current Javits measure, introduced by Sens. Ralph E. Flanders (R Vt.) and Irving M. Ives (R N.Y.) in 1949 and reintroduced over a period of six years, proposed a combination of federal and state subsidies to underwrite losses incurred under low-cost insurance programs administered by state agencies. Vice President Nixon, then a representative from California, was one of a group of younger congressmen who introduced a companion to the Flanders-Ives measure in the House in 1949.

A good deal of the steam went out of the health insurance issue when Truman left the White House. Little enthusiasm on either side of the fence was stirred by President Eisenhower's reinsurance proposal of 1954. Under that plan the federal government was to lend \$25 million to a federal reinsurance fund which would pay 75 per cent of a private company's losses on reinsured contracts. The government was to be repaid from reinsurance premiums paid in by the insurance carriers. The purpose of the reinsurance plan was to encourage the private companies to insure high-risk individuals.

A revised version of the plan, advanced by the administration in 1955, would have provided \$25 million in federal loans for each of four separate funds covering different types of programs. Another approach based on the reinsurance principle, suggested by the Secretary of Health, Education and Welfare in 1956, was taken in bills to amend the antitrust laws to allow private insurance companies to establish a joint reserve fund to cover losses on poor risks.

MEDICAL AID TO THE AGED IN OTHER COUNTRIES

A recent survey shows that at least 33 countries have some sort of governmental provision to help older members of the population meet the costs of medical care.⁶ Eight

⁶ Daniel S. Gerig and Carl H. Farman, "Medical Benefits for Pensioners Under Foreign Social Security Programs," *Social Security Bulletin*, January 1960, p. 11.

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countries—Australia, Bulgaria, Iceland, New Zealand, Norway, Sweden, U.S.S.R., United Kingdom—furnish health services to everyone without regard to age. The British system is financed largely from general revenues, supplemented by a social insurance contribution. In Norway and Sweden, all heads of families must belong to a health benefit organization supported by contributions from employers, employees and the government, but pensioners do not have to pay into the system.

Twelve countries — Albania, Czechoslovakia, Belgium, France, East Germany, West Germany, Greece, Hungary, Italy, Poland, Rumania, Yugoslavia—provide medical benefits under old-age insurance programs and relieve workers of the obligation to contribute after they retire. The programs vary in scope but generally provide the same benefits for retired persons as for job-holding individuals. The Belgian system is financed by a 7 per cent tax, divided between employer and employee, and a smaller government contribution supplemented occasionally by additional subsidies. Benefits take the form of cash reimbursement up to 75 per cent of the expenses incurred for medical care.

In France the combined pension-sickness insurance is financed by employer (12½ per cent) and employee (6 per cent) contributions, and beneficiaries are reimbursed up to 80 per cent of the cost of doctor and hospital bills. Italy's medical benefit program for pensioners was launched in 1955; since then, benefits for treatment of certain diseases of old age have been made available without limit of time.

Six countries require retired persons to pay for sickness insurance: Austria, Chile, Luxembourg, Mexico, Panama and Spain. Pensioners in Austria pay \$2.28 a month for protection which includes hospitalization, doctor's care, and medicines. Mexico requires pensioners, to whom medical insurance was extended in December 1956, to pay 2 per cent of their pensions, the same rate as the wage percentage paid by workers. Care is provided mainly in clinics and in hospitals maintained by the government.

Four countries—Denmark, Netherlands, Peru, Switzerland—offer voluntary insurance to pensioners under a public program. In Denmark, pensioners pay on the average around 60c a month for membership in a sickness club

which provides free medical care, hospitalization, 75 per cent of essential medicines, and a daily cash benefit of about 15c. The Netherlands has a similar program for pensioners whose incomes do not exceed a certain sum (around \$930 a year).

Canada adopted a system of hospitalization insurance for persons of all ages in 1957. The Dominion government offered to pay one-half the cost of programs administered by the provinces, and all the provinces except Quebec agreed to participate. Ireland furnishes free medical services, hospitalization, and medicines, chiefly through public facilities, to persons of low income. Japan has two health insurance systems, a compulsory plan for workers and a voluntary plan for householders not gainfully employed. For the latter group, which includes most of the oldsters, the insurance carrier is the municipality.

Present Health Insurance for Elderly

THE GREAT GROWTH of private health insurance in the United States in recent years has been cited frequently by opponents of a federal program of medical aid to the aged. With private insurance moving ahead so rapidly, they assert, it will not be long before most old people will have protection, and nothing more will be needed except public assistance through conventional channels for a declining number of indigent men and women. Others insist, however, that private insurance never can do an adequate job of providing the benefits needed at a price the aged can pay. It is their contention that only a governmental program, nation-wide in scope, can completely remove the medical-financing hazards of old age.

EXTENT OF VOLUNTARY COVERAGE OF OLD PEOPLE

More than 123 million Americans now have some form of voluntary health insurance. The total includes 111 million with surgical as well as hospitalization coverage, 75 million with insurance against ordinary medical expenses, and 17 million with major medical expense insurance against catastrophic illness.⁷ Coverage varies according to

⁷ Health Insurance Institute, *Health Insurance Data* (1959). The figures are as of the end of 1958.

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age and income and is least extensive in the group of persons aged 65 or more.

The most recent national survey of health insurance coverage among the elderly was made in March 1957 by the National Opinion Research Center of the University of Chicago in cooperation with the Health Information Foundation. It showed that nearly 39 per cent of those aged 65 or more were covered by health insurance. In the same year a Department of Health, Education and Welfare survey found that 43 per cent of all O.A.S.I. beneficiaries were insured for medical benefits. U.S. Census Bureau surveys indicated that the proportion of persons over 65 with health insurance rose from 26 per cent in 1952 to 36 per cent in 1956.

The general survey in 1957 disclosed that nearly all insured older persons were covered for hospital costs; two-thirds had additional insurance for medical services; and one-fifth were covered for the cost of home and office visits with the doctor. Approximately one-third were insured for the entire cost of the services covered, while the remainder were covered for only a part of the cost.

Growth of coverage among older persons, which recently has outstripped the rate of health insurance growth among the population generally, is attributed largely to a trend toward retention of insurance acquired under employee group plans. To a lesser extent health insurance has spread among the aged as the result of new individual policies offered directly to persons in their upper years.

TYPES OF HEALTH INSURANCE AVAILABLE AT AGE 65

Seven forms of health insurance are currently available to older persons. Some of the plans are new and to some degree experimental.

1. Continuation of group insurance coverage for older persons who remain at work beyond the usual retirement age. This practice is fairly general.

2. Continuation of group insurance for retired workers and their dependents, with the employer still paying all or a part of the premium. This type of insurance extension has been growing since 1952 but is not yet widespread; it applies chiefly to individuals who worked for one employer over a long period.

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3. Continuation of insurance, acquired as a member of an employee group, through conversion to an individual policy on retirement. The right of conversion is becoming increasingly prevalent in employee group policies, but rates for the converted policy tend to be higher and the insured person may lose the benefit of the employer's contribution.

4. Issuance of group insurance to persons already of advanced age. This is a new form of insurance offered by a few companies to associations of retired persons, golden age clubs, housing colonies for retired persons, and similar groups.

5. Continuation of individual insurance purchased during a person's productive years. At least 175 insurance companies are said to provide this form of insurance; 32 of them issue policies guaranteed renewable for life; 58 are said to "voluntarily restrict their right to refuse renewal of coverage in instances where the health of the policyholder deteriorates."⁸

6. Issuance of new individual policies to persons in advanced age. At least 122 insurance companies are reported to issue policies to individuals above age 64, some up to age 80, and a few without age limit. Two big companies have widely advertised the availability of coverage to persons of any age above 64, regardless of their condition of health. These companies use the "mass enrollment" approach, attempting to sign up large numbers in a designated area during a limited period of intense promotional activity. They thus obtain the broad range of risks typical of group coverage.

7. Issuance of health insurance during the productive years which becomes paid up at age 65. The premium rates are necessarily higher than normal to cover the years of high risk and non-payment. This type of insurance is not widespread.

HIGH PREMIUM RATES AND RESTRICTION OF BENEFITS

Insuring the health of the aged is obviously a more expensive undertaking than insuring the health of others, because the elderly as a rule incur more medical expenses. A Department of Health, Education and Welfare study of

⁸J. F. Follmann, Jr. (Director of Research of Health Insurance Association of America), "A Challenge to Industry and Insurance," reprinted from *Insurance Law Journal*, December 1969.

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health insurance suggests that the cost of providing benefits to persons over age 65 may be $2\frac{1}{2}$ times that of supplying the same benefits to members of a younger group. For this reason, the older person usually either has to pay a higher premium or take fewer benefits. This is almost always the case when a member of an employee group continues health insurance into retirement, particularly if he must convert to an individual policy.

Commercial insurance rates are based on anticipated costs. If a group policy provides benefits to retired persons as well as to employed persons, the additional cost is spread over all members of the group, resulting in a higher overall premium rate. The extra cost of providing benefits for the high-risk group of retired persons is thus borne in part by the younger, low-risk workers. But there are financial hazards in plans of this type. The H.E.W. study cited a concern which had experienced a sharp decline in the size of its work force, with the result that pensioners came to represent 25 per cent of the covered group. More typically, there would be 5 to 10 pensioners for every 100 active workers. If the ratio is 5 to 100 and experience indicates that the medical expenses of the pensioners amount to two and one-half times those of the active group, the cost of the premium for each member would be $7\frac{1}{2}$ per cent more than if the plan were restricted solely to active workers.⁹

Many group plans carrying benefits for retired workers include safeguards against excessive drains resulting from higher costs for older members. Liability for medical expenses of a retired person may vary, like the size of his pension, according to the number of years he has worked for the company. In some plans a lifetime limit of benefits is set, ranging usually from \$1,000 to \$5,000; coverage ends when benefits are exhausted.

Similar problems in coverage of the aged are faced by Blue Cross, Blue Shield and other non-profit plans whose premium rates are based on the medical expense liability of a community. Most but not all of these plans spread the costs of high-risk enrollees over all participants, but some provide fewer benefits or charge higher rates to older enrollees. Only 11 of the 79 Blue Cross plans offer individual insurance to persons over 65, and the insured in

⁹ Department of Health, Education and Welfare, *Hospitalization Insurance for OASDI Beneficiaries* (report to House Ways and Means Committee, 1969).

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that age bracket either are charged more or receive fewer benefits. An American Hospital Association official, noting recently that much of the health insurance available to older persons is inadequate, observed that "There is little reason to believe that the Blue Cross plans . . . can enroll aged persons who, upon retirement, lose their protection under a private insurance contract." Insuring such persons would raise premiums for the plan's younger members.¹⁰

One of the new group plans for retired persons charges \$72 a year per person for benefits of \$10 a day for 31 days of hospitalization, 50 per cent of miscellaneous hospital expenses up to a maximum of \$125, and a surgeon's fee of up to \$200. Benefits do not apply to any condition for which the insured was hospitalized in the 12 months preceding membership in the group, and six months must elapse before claims can be made for recurrence of the same or a related illness.

Non-cancellable policies are usually more expensive than those which may be terminated by the insurer. A new "lifetime renewable safeguard policy," available to individuals aged 65 to 75 and requiring a health statement, offers several combinations of benefits based on the premium paid. A typical "package," costing \$89.40 per person a year, would provide, for each period of illness separated by six months, \$10 daily for 30 days of hospitalization, hospital extras up to \$50 each for medicines and appliances, \$25 for operating room, surgical dressings, blood transfusion and oxygen, \$20 for X-ray and anesthetic, \$15 for laboratory, and a sliding scale for surgeon's fees up to a \$200 maximum.

Prudential Insurance Co. announced in April a new group health insurance policy which continues coverage of individuals into retirement. For \$6.80 a month, the retired person would be eligible for \$12 a day hospitalization up to 70 days, a maximum of \$100 for other hospital services, and a maximum of \$200 for surgery. To obtain coverage for more services, higher rates would have to be paid. At the maximum, \$11 a month, a retired worker would be entitled to \$20 a day for 100 days of hospitalization, \$200 for extras, and \$400 for a surgeon's fee.

¹⁰ Kenneth Williamson, testimony before Senate Subcommittee on Problems of the Aged and Aging, Aug. 5, 1969.

Arguments in the Social Insurance Fight

ARGUMENTS raised in the debate over health insurance for the aged differ little from those heard when compulsory health insurance for everyone was a major issue. The line-up for and against pending measures is likewise nearly identical. Organized labor and liberal groups like Americans for Democratic Action (now joined by old people's organizations) are in the forefront of the drive for the Forand bill or similar legislation. The American Medical Association, the insurance industry, and leading business organizations like chambers of commerce and the National Association of Manufacturers lead the opposition.

The political alignment also repeats itself. Supporters of the Forand bill belong largely to the ranks of liberal Democrats, while the open opposition comes largely from Republicans. In both parties, however, there is a middle group which would be willing to support a voluntary public program to help old people meet their medical expenses, but which opposes seeking the objective through a compulsory program.

It is contended by the insurance industry that a compulsory government insurance program would cut short the rapid growth of voluntary insurance. Private insurance, despite its present shortcomings, is said to be better able to meet old people's problems because it is flexible and can be adjusted to fit an individual's needs and circumstances.

The insurance industry disputes the "unsound assumption that most of the aged population of our country are not able to finance their health care costs."¹¹ The low-income figures cited in various statistical reports are said to ignore other assets possessed by many old people which make it possible for them to purchase health insurance or pay medical expenses as they come along. The only real problem, according to this view, is that of providing for the indigent. It is asserted that their many problems can be handled better through existing channels of public assistance to the needy.

The medical profession endorses these arguments and

¹¹ J. F. Follmann, Jr., "A Challenge to Industry and Insurance," reprinted from *Insurance Law Journal*, December 1959.

adds the familiar contention that compulsory medical aid to the aged would be a step into "socialized medicine" that would end in compulsory health insurance for the whole population. American Medical Association witnesses testified before the Ways and Means Committee last July that financing of health benefits through social security would lead to government control over the purveyors of medical services, cause over-use and overcrowding of hospitals, and impair doctor-patient relationships. They asserted that it would cause deterioration of existing medical care of the aged by undermining the joint efforts of doctors, nurses, social workers, insurance company personnel and others, in conjunction with local community leaders, to develop broad-based programs to improve the general well-being of old persons.

Questions are raised as to the advisability of piling new charges on the social security system, particularly in view of scheduled increases in social security taxes to support the basic program. Although any number of studies have been made on the condition of the aged, more specific data on the extent of their need for aid in financing health care are said to be desirable. And present information is believed insufficient to show how high eventual charges on the social security system would be if the medical aid program should be enacted.

Proponents of the Forand proposal insist that it offers the only feasible method of meeting the problem adequately. By providing benefits as a right, it would prevent pauperization of the elderly in times of illness. Any plan which attempts to underwrite voluntary private insurance for the aged of limited means is called simply a subsidy to the insurance industry. As for the cost of the Forand program, it is pointed out that public expenditures for public assistance to the aged are already heavy—the federal contribution for old-age assistance alone is more than \$1.1 billion a year—and that insurance under social security would provide a less painful way of defraying the cost than to make appropriations from the general treasury.



